**Patient Information:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Married: \_\_\_\_\_ Single: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Phone Numbers:

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot/Apt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information:**

Please check any of the following illnesses you have nor or have had in the past:

\_\_\_\_\_ AIDS/HIV \_\_\_\_\_ Epilepsy

\_\_\_\_\_ Latex Allergy \_\_\_\_\_ Excessive Bleeding

\_\_\_\_\_ Arthritis \_\_\_\_\_ Hepatitis

\_\_\_\_\_ Artificial Joints \_\_\_\_\_ Radiation Therapy

\_\_\_\_\_ Cancer \_\_\_\_\_ Tuberculosis

\_\_\_\_\_ Chemotherapy \_\_\_\_\_ Tumors

\_\_\_\_\_ Claustrophobia \_\_\_\_\_ Alzheimer’s

\_\_\_\_\_ Diabetes \_\_\_\_\_ Dementia

Are you Pregnant: \_\_\_\_\_ yes \_\_\_\_\_ no Breastfeeding: \_\_\_\_\_ yes \_\_\_\_\_ no

Are you currently taking any medications: \_\_\_\_\_ yes \_\_\_\_\_ no

List:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all of this information provided above is correct:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient, parent, power of attorney, or guardian